Initial Approval: October 11, 2017

CRITERIA FOR PRIOR AUTHORIZATION

Tremfya™ (guselkumab)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Guselkumab (Tremfya™)

CRITERIA FOR MODERATE TO SEVERE PLAQUE PSORIASIS: (must meet all of the following)

- Patient must have a diagnosis of moderate to severe plaque psoriasis
- Patient must be 18 years or older
- Patient must have failed to respond or have lost response to other systemic therapies
- Must be prescribed by or in consultation with a Dermatologist or Rheumatologist
- Evaluation for latent tuberculosis infection with TB skin test prior to initial PA
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has taken an oral DMARD agent for the treatment of plaque psoriasis (see attached table)
- Patient is a candidate for systemic therapy or phototherapy

LENGTH OF APPROVAL: 12 MONTHS

Notes:

- Recommended dose is 100 mg at Week 0, Week 4, and every 8 weeks thereafter

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR	PHARMACY PROGRAM MANAGER DIVISION OF HEALTH CARE FINANCE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
_____	_____
DATE	DATE

Biologic Agents	
Generic Name	**Brand Name**
Abatacept	Orencia®
Adalimumab	Humira®, Amjevita®, Cyltezo®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Tocilizumab	Actemra®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Etanercept	Enbrel®, Erelzi®
Tofacitinib	Xeljanz®, Xeljanz XR®
Ustekinumab	Stelara®
Secukinumab	Cosentyx®
Vedolizumab	Entyvio®
Canakinumab	Ilaris®
Apremilast	Otezla®
Ixekizumab	Taltz®
Infliximab	Remicade®, Inflectra®, Renflexis®
Brodalumab	Siliq®

Oral Plaque Psoriasis Therapy	
Generic Name	**Brand Name**
Acitretin	Soriatane®
Cyclosporine	Sandimmune®
Methotrexate	Trexall®, Rheumatrex®